UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

HUMAN RESOURCES
DIVISION

August 6, 1982

B-208447

The Honorable Max Baucus
United States Senate

Dear Senator Baucus:

Subject: Impact of Medicare Reimbursement Limits on Small Rural Hospitals (GAO/HRD-82-109)

This is in response to your March 23, 1982, request that we review the impact on small rural hospitals of Medicare's routine inpatient hospital operating cost reimbursement limits, which are established under section 223 of the Social Security Amendments of 1972 (Public Law 92-603). You also asked that we review the Health Care Financing Administration's (HCFA's) implementation of these limits and the program to exempt sole community providers (SCPs) from the limits. We discussed your request with your office and agreed to review (1) the legislative and regulatory basis for the SCP exemption, (2) the effect of SCP exemptions on small rural hospitals, (3) the administration of the SCP exemption program, and (4) a sample of Montana hospital SCP cases to see if all the relevant factors were considered.

Our analysis of the reimbursement limits' impact on rural hospitals indicates that those with fewer than 50 beds are being affected comparatively more than larger hospitals. If a separate reimbursement limit were established for rural hospitals with fewer than 50 beds, the impact on them would be reduced while Medicare could save an estimated $3.7 million because of the resulting revised limits on other hospitals. Regarding the SCP exemption program, HCFA needs to better define the important terms and criteria related to it. HCFA should also assure that the program is implemented uniformly across the Nation.

(106229)

OBJECTIVES, SCOPE, AND METHODOLOGY

To determine the impact of the section 223 limits on small rural hospitals, we reviewed HCFA's computer list of the impact on all rural hospitals with 1 to 99 beds contained in the data base used to establish the limits for these hospitals. This list gives for each hospital (1) the number of covered Medicare days for the base cost reporting year, (2) HCFA's estimate of the routine costs for the year the reimbursement limits will be in effect, and (3) the reimbursement limit for the hospital. To determine the effect that changing the bed size group would have on the limits' impact, we had HCFA reprogram the computer to calculate by hospital the reimbursement limits for bed size groups of 1 to 50 beds and 51 to 99 beds. We reviewed the same data for these new groups as HCFA had provided for the currently used group of 1 to 99 beds. We also reviewed data related to occupancy rates by hospital bed size groups because differences in occupancy rates can lead to large differences in hospital routine costs.

To minimize HCFA's effort in providing us data and to help assure we obtained the data quickly, we agreed to accept data in which the reimbursement limits are based on 112 percent of the mean costs of the hospitals in the bed size groups used. Current Medicare law (effective October 1, 1981) requires the reimbursement limits to be set at 108 percent of mean costs. Although all of the data in this report are based on limits set at 112 percent of mean costs, the data are indicative of the impact of the reimbursement limits currently in use. The primary differences between limits set at 112 percent and those set at 108 percent are that the latter would affect more hospitals and projected savings would be about 4 percent higher per hospital affected.

To evaluate the SCP exemption program, we reviewed the legislative history of section 223 and HCFA headquarters and regional office documentation related to SCP exemptions. We discussed the program with officials of HCFA and selected intermediaries that administer Medicare for HCFA under contract.

To determine whether all pertinent factors were considered in evaluating the SCP status of Montana hospitals, we took a sample of those hospitals and obtained and reviewed all of the relevant documentation from HCFA's Denver Regional Office.

Our audit work was performed at HCFA headquarters in Baltimore, Maryland, and by telephone with HCFA's 10 regional offices. Our work was conducted in accordance with the Comptroller General's current standards for the audit of governmental organizations, programs, activities, and functions.

SECTION 223 LIMITS AND THE SCP EXEMPTION PROGRAM

Medicare reimburses hospitals for the cost of providing covered services to beneficiaries. Before 1974, Medicare would pay all costs incurred by hospitals as long as they were related to patient care, reasonable, and not out of line with the costs of comparable providers. In 1972, the Congress enacted a provision permitting the Department of Health and Human Services (HHS) to establish additional limits on the reimbursable costs of providers. Section 223 of the Social Security Amendments of 1972 provided that HHS could establish limits on:

> "* * * the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by [Medicare]."

According to the Senate Committee on Finance report (S. Rep. No. 92-1230, p. 187) the provision was intended to curtail Medicare reimbursement of costs stemming from "* * * marked inefficiency in operation or conditions of excessive service" and to limit reimbursement to costs that would normally be incurred "* * * by a reasonably prudent and cost-conscious management." The Committee reasoned that health care institutions should expect to suffer the financial consequences of inefficient operations. The House Committee on Ways and Means report (H.R. Rep. No. 92-231) contained similar language.

Under authority of section 223, HHS through HCFA has established, beginning in 1974, limits on the amounts it will pay for hospital inpatient routine operating costs (such costs as room and board and routine nursing services). The limits are established for various groups of hospitals based on bed size ranges for urban and for rural hospitals. 1/ To establish the limits, HHS currently determines 108 percent of the mean of routine costs for hospitals within each group. The limit applied to each hospital is designed to reflect wages in its area and is adjusted upward if the hospital has an approved teaching program or is in a State where the number of covered days of care per 1,000 Medicare beneficiaries is less than the national average.

1/HHS has defined "rural hospitals" to include all hospitals not located in a county within a standard metropolitan statistical area (SMSA).

Medicare reimbursement of costs in excess of the limits 1/ is precluded except in certain specified cases. By regulation HHS has provided exceptions and exemptions to the reimbursement limits for providers that meet certain conditions. The most often used exemption is the SCP exemption, which exempts providers from the limits if they are the only provider reasonably accessible to beneficiaries in their area. HHS based allowing this exemption on the language of the Senate Committee on Finance and House Committee on Ways and Means reports cited above, which stated:

> "* * * the provision will not be applicable where there is only one hospital in a community - that is, where, if the provision were applied, additional charges could be imposed on beneficiaries who have no real opportunity to use a less expensive, non-luxury institution, and where the provision would be difficult to apply because comparative cost data for the area are lacking."

IMPACT OF REIMBURSEMENT LIMITS ON SMALL RURAL HOSPITALS

The limitations on hospital reimbursement are derived from the reported per diem inpatient routine costs of Medicare providers. Providers are classified according to their bed size and location (SMSA or non-SMSA) so that the costs of similar hospitals are compared. Data from providers' cost reports for the base year (usually 3 years before the year to which the limits apply) are used to develop the limits. Under current law, the hospital inpatient routine limits are set at 108 percent of the mean cost for each comparison group. The base year limit is then adjusted by

---

1/Beneficiaries may be charged by providers for costs exceeding these limits, but only if

- --HHS notifies the public that the particular provider will charge beneficiaries an amount in excess of what has been determined necessary for the efficient delivery of services and
- --the provider informs the beneficiary of the charges and that they are in excess of the costs determined to be necessary for the efficient delivery of services.

According to HCFA officials, no hospital has ever charged beneficiaries for amounts reduced by the section 223 limits.

various factors 1/ to project expected routine service cost increases for the year to which the limits apply. Generally, provider costs in excess of the limits are not reimbursed by Medicare. These unreimbursed amounts represent a savings to the program.

HCFA estimated that $197.9 million would be saved in the year ended June 30, 1982, as a result of hospital limits being set at 112 percent of the mean. Of this total about $37 million was projected to result because 524 rural hospitals were projected to exceed the limit; $15.6 million (42 percent) was projected to result from 390 rural hospitals with fewer than 100 beds being over the limit. An analysis of HCFA's projected savings follows:

Bed size category	Number of providers	Number of providers affected	HCFA's projected savings
			(000 omitted)
SMSA 685 and above	104	20	$ 47,970
SMSA 405-684	393	66	44,119
SMSA 100-404	1,636	276	59,976
SMSA Fewer than 100	719	134	8,765
	2,852	496	160,830
Rural 170 and above	263	56	12,717
Rural 100-169	430	78	8,699
Rural Fewer than 100	2,124	390	15,633
	2,817	524	37,049
Total	5,669	1,020	$197,879

Basically, savings are projected based on the difference between the reimbursement limit and the hospital's projected costs times the number of days of covered care provided in the base year. The estimated savings do not exclude providers for which no savings would be realized because they are exempted from the limits. Our analysis showed that, if exempted hospitals were excluded from the projections, the number of small rural hospitals affected would be reduced from 390 to 284 (27 percent) and the projected savings would be reduced from $15.6 million to $11.1 million (29 percent).

1/Including adjustments for changes in wages and the cost of goods and services purchased by the hospitals.

Of the 234 exemptions granted to July 1982, 206 (about 90 percent) applied to rural hospitals with fewer then 100 beds. (For a State-by-State analysis, see enc. I.)

We noted that HHS originally established a separate limit for rural hospitals with fewer than 55 beds. We also noted that, of the 390 rural hospitals in the 1- to 99-bed group, 325 (83 percent) had 50 or fewer beds. Therefore, the impact of the current reimbursement limits fell primarily on the smaller hospitals.

To determine if combining rural hospitals with 55 to 99 beds into this cell had increased the impact of the limits on very small hospitals, we requested HCFA to split the existing rural hospital category of fewer than 100 beds (2,124 hospitals) into two categories of 1 to 50 beds and 51 to 99 beds. By splitting the cells, on the average, the limits on rural hospitals with 1 to 50 beds would increase by about $7 per covered day of care, while the limits on rural hospitals with 51 to 99 beds would decrease by about $10. For example, the lowest current reimbursement limit for a hospital in Nevada is $145.95. After splitting the cell, the lowest limit would be $152.80 (an increase of $6.85) for a hospital of 1 to 50 beds and $135.43 (a decrease of $10.52) for a hospital of 51 to 99 beds. (For a State-by-State analysis, see encs. I and II.)

We also computed the number of hospitals affected and the projected savings that would result from splitting the 1- to 99-bed rural hospital group.

	HCFA group of fewer than 100 beds	GAO groups		
		1 to 50 beds	51 to 99 beds	Total
Providers affected	390	262	175	437
Estimated savings	$15,633,000	$9,330,000	$10,122,000	a/$19,452,000
Less savings that would not occur because hospitals are exempted	(4,501,000)	(2,744,000)	(1,835,000)	(4,579,000)
Adjusted savings	$11,132,000	$6,586,000	$ 8,287,000	$14,873,000

a/Our savings are computed differently from HCFA's savings, which are adjusted to take into account estimated changes in the hospital staff-to-patient ratio and other factors not considered in our computations.

By splitting the existing cell, an adjusted additional savings of about $3.7 million would result. (For a detailed analysis, see enc. III.)

We reviewed the occupancy rates of rural hospitals to see if this factor could explain the changes resulting from splitting the 1- to 99-bed group. For the 47 States with rural hospitals of this size included in HCFA's data base, we noted a marked difference in national average occupancy rates between hospitals with 1 to 50 beds (52.3 percent) and those with 51 to 99 beds (63.8 percent). In 46 of the 47 States, the occupancy rates were higher for the latter category. The differences ranged from 0.5 to 31.8 percentage points. We believe that the difference in occupancy rates accounts for at least part of the difference in hospital costs, and hence the cost limits, when the 1- to 99-bed group is split. Hospitals with low occupancy rates can have higher average costs because there are fewer patient days per bed on which to spread fixed costs. We do not know to what extent the lower occupancy rate for smaller rural hospitals (1) is justified by the need for standby capacity or (2) is the result of building beds in excess of those justified by need.

Before 1975 the limits included two groups for small rural hospitals--1 to 54 beds and 55 to 99 beds. HCFA informed us that its files

> "* * * suggest that the number of bed size groups was reduced because moving to the smaller number did not greatly reduce the comparability among hospitals in each group so the resulting limits were equitable for hospitals in the expanded groups."

PROGRAM POLICY ON SCP EXEMPTIONS

Regulations implementing section 223, including those related to the SCP exemption for hospitals, are contained in 42 CFR 405.460. The regulations state that an exemption may be granted to hospitals when:

> "(1) * * * The hospital, by reason of factors such as isolated location or absence of other hospitals is the sole source of such care reasonably available to beneficiaries."

To apply for an exemption a provider must either (1) have incurred actual costs that exceed its reimbursement limit or (2) wait until it files a cost report. The provider is responsible for providing necessary data to support the request for an exemption.

Under existing policy, while a provider cannot request a review of HCFA's decision to deny an SCP request, it can appeal reimbursement reductions occurring because its costs were over the limits. Also, intermediaries are required to review the exemption each year to assure that circumstances have not changed and that the exemption is still warranted.

Medicare guidelines for the SCP exemption were established in two Intermediary Letters issued in July 1974 (I.L. 74-22) and April 1978 (I.L. 78-17). Intermediary Letters are used to transmit clarifications of HCFA's policy. They are general program instructions and, according to a HCFA official, are not required to be published in the Federal Register or issued by HCFA as proposed rules for comment.

Before 1978, HCFA headquarters was responsible for making the final determination as to whether a hospital qualified for an exemption. Under current policy, HCFA's regional offices review SCP exemptions. According to HCFA officials, this change was made because the regional offices have a better idea of unusual local circumstances that might affect a hospital's eligibility for an SCP exemption. In all cases, the provider's intermediary makes a recommendation about whether to grant an exemption after reviewing the data furnished by the provider.

HCFA's SCP policy generally precludes approving an exemption for providers located within an SMSA or within 25 miles of a similar facility. An April 1978 revision stated that a community's dependence on a provider for care would be indicated by the extent to which and the reasons why residents of the requesting hospital's service area travel to other similar facilities for care. The data reporting requirements for providers applying for the SCP exemption were expanded to include (1) the type and size of the hospital; (2) the geographic boundary of its service area; (3) the population of its service area and the population's distribution throughout this area; (4) the admitting patterns of physicians who practice in the service area (i.e., the extent to which these physicians admit residents of the service area to other similar facilities); and (5) the identity, location, and size of the nearest similar facilities located in or with service areas adjacent to the hospital's service area.

However, key terms were not defined, and specific criteria for evaluating exemption requests were not established. Furthermore, the guidance did not specify how the supporting documentation should be developed and corroborated.

HCFA policy permits regional offices to issue instructional material designed to elaborate on general program instructions and to adapt them to local conditions. Two regions--Denver and San Francisco--have issued special instructions on SCP policy. HCFA policy does not require headquarters approval or subsequent review of regional instructions.

In April 1982, HCFA's Denver Regional Office issued special SCP policy instructions which discussed the intent of the SCP exemption and established several methods for determining a hospital's isolation as indicated by its utilization patterns. 1/ Denver requires that 65 percent of the service area residents use the requesting hospital. The policy, in part, allows a hospital to meet the 65-percent utilization criterion if Medicare beneficiaries in its service area use it at this level and also permits the deduction from utilization when services used are not available at the requesting hospital.

HCFA's San Francisco Regional Office issued instructions relating to SCP policy in October 1979 and modified them in December 1980. The instructions required the region's intermediaries to consider the utilization of "all services" in determining if other hospitals serve as alternative sources of care for the requesting hospital's service area residents. Previous policy permitted the deduction of utilization of other hospitals for care unavailable at the requesting provider in making an SCP determination.

PROBLEMS WITH THE ADMINISTRATION OF SCP EXEMPTIONS

Correspondence among HCFA headquarters, HCFA regional offices, and fiscal intermediaries, as well as discussions with program officials responsible for implementing SCP policy, indicate several problems. These problems stem from the lack of definition of certain key terms in the guidelines, the absence of specific criteria for evaluating exemption requests, and difficulties in obtaining necessary data.

Definitional problems

According to HCFA headquarters officials, broad guidelines are necessary to allow the regional offices maximum flexibility in implementing the policy. However, according to several regional office and intermediary personnel we contacted and correspondence we examined, the absence of definitions and specific standards is

---

1/The rate at which residents of a provider's service area obtain care at that and other hospitals.

the major factor complicating the SCP decisionmaking process. Moreover, because many of the terms appearing in the SCP instructions are interrelated, the absence of definitions and standards contributes to inconsistent policy application among HCFA regions.

Terms such as "like facility," "community," and "service area" need to be clarified. For example, the determination of a hospital's service area is central to evaluating whether Medicare beneficiaries depend on the provider for care. However, this determination is often a subjective judgment. In practice, the definition is often left up to the provider requesting the exemption. HCFA regional office and intermediary personnel we contacted stated that requesting providers often "shrink" their service area in order to exaggerate the residents' dependence on them for care. For example, in one request we examined, the provider described its service area as having only a 10-mile radius, apparently because reducing the radius from 20 miles resulted in more than 80 percent of its service area residents using it for care. Eighty percent was the lowest level permitted for an exemption in this case.

In a May 1982 memo to its Seattle Regional Office, HCFA indicated that a hospital's service area should be defined by the local health planning agency or other appropriate local authority rather than by the hospital.

Problems with lack of criteria

There is a lack of specific criteria for evaluating exemption requests. Some of HCFA's regional offices and intermediaries have encountered confusion in applying the 25-mile and utilization criteria. For example, HCFA's SCP guidelines do not specify utilization standards, define the population whose utilization patterns are to be measured, or provide guidance on how to account for differences in the availability of services among adjacent providers. Furthermore, utilization statistics are often difficult for providers to obtain. According to HCFA officials, hospitals often have difficulty getting statistics on utilization of nearby hospitals by residents of their service area. As a result, HCFA regions differ widely in the determination of a community's reliance on a provider for care.

For example, the differences in SCP criteria between the Denver and San Francisco Regional Offices, discussed on page 9, could result in a different determination for a given hospital. The Denver Regional Office allows providers to deduct the use of other hospitals' services that are unavailable at the requesting provider. However, HCFA recently directed its Seattle Regional Office not to factor out patients utilizing services at other hospitals not available at the requesting provider.

STATISTICS ON EXEMPTED HOSPITALS

HCFA's central office did not maintain a list of hospitals that have received SCP exemptions. HCFA officials told us that neither its regional offices nor its intermediaries maintain a complete list of exempted providers. 1/ We obtained documentation from HCFA's headquarters and regional offices and spoke to regional and intermediary officials to obtain information on the number of SCP applications and their disposition.

The information we obtained indicates that 374 hospitals 2/ have applied for the SCP exemption since it was established in 1974. Of these, 234 applications were approved, 117 were denied, and 23 were pending as of July 1982. (For a regional and State analysis, see enc. IV.)

DENIED SCP REQUESTS FOR MONTANA HOSPITALS

As of July 1982, 21 Montana hospitals had applied and had their applications for SCP exemptions acted on. We reviewed seven decisions (four denials and three approvals) by obtaining all correspondence concerning these cases from HCFA's Denver Regional Office. The correspondence for the four denied cases indicated the decisions were based primarily on the fact that a similar provider existed within a 25-mile radius of the hospital applying for the exemption.

Distance, however, is only one of the factors that are supposed to be considered. For example, in all four of the denied cases, apparently no consideration was given to the extent to which patients from the applying hospital's area obtained care from other hospitals. After completing our review, we were told that one of the denied hospitals we reviewed was later granted an exemption.

Similarly, in all three approved cases, there was no indication of the consideration given to the extent to which patients from the applying hospital's area obtained care from other hospitals.

1/HCFA has recently required its intermediaries to "flag" exempted providers' cost reports, but because many intermediaries have not yet identified these providers, no complete list had been developed as of July 1982.

2/Not included are 27 hospitals in Washington State which either gave up their exemptions to participate in a demonstration project or have closed.

However, because of the minimal documentation available, we could not determine for the seven cases if the Denver Regional Office had made appropriate decisions.

On April 1, 1982, the HCFA central office advised the region that it had reviewed some SCP exemption request decisions and found that a disproportionate emphasis had been placed on the 25-mile criterion. The regional office was urged to review its denials to assure that all pertinent factors had been considered. We were advised by a regional office official that, as of July 1, 1982, these cases had not been reviewed but would be when the intermediary completes its utilization study of Montana hospitals.

CONCLUSIONS AND RECOMMENDATIONS

HCFA's current reimbursement limits for rural hospitals with fewer than 100 beds primarily affect hospitals with 50 or fewer beds. Splitting the 1- to 99-bed rural hospital group would reduce the impact of the reimbursement limits on the smaller hospitals and increase the impact on the larger hospitals. The smaller rural hospitals generally have lower occupancy rates than the larger rural hospitals; this fact can lead to higher per patient day costs for the smaller hospitals. This results because with lower occupancy rates there are fewer patient days per bed over which a hospital's fixed costs can be spread.

The data we obtained indicate that the impact of the reimbursement limits on small rural hospitals could be more equitably spread among them if the current group of 1 to 99 beds were split into two groups of 1 to 50 beds and 51 to 99 beds. Such a split should also result in additional Medicare savings.

HCFA's method of estimating the savings resulting from hospital reimbursement limits overstates the savings because it does not exclude "savings" from providers exempted from the limits. We believe exempted providers should be excluded in making these estimates.

Both intermediary and regional officials have encountered trouble implementing the SCP exemption criteria because of the lack of (1) definitions for key terms and (2) a standard approach to evaluate SCP applications. We believe that HCFA could achieve a more uniform application of the SCP exemption by defining key terms in the existing instructions and providing a standard approach to the regions to evaluate exemptions. This would also help assure a uniform approach to granting SCP exemptions nationwide.

Accordingly, we recommend that the Secretary of Health and Human Services direct the Administrator of HCFA to

--redefine the group size and establish new limits for small rural hospitals to assure that the limits affect such hospitals equitably,

--eliminate exempted providers from computations of expected savings that will result from the reimbursement limits, and

--define key terms and provide intermediary and HCFA regional office staff with a method of evaluating key factors used to determine if a hospital is entitled to an SCP exemption.

As requested by your office, we did not obtain comments from HHS on this report. As arranged with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from its issue date. At that time we will send copies to interested parties and make copies available to others upon request.

Sincerely yours,

Edward A Densmore

for Gregory J. Ahart
Director

Enclosures - 4

ENCLOSURE I

IMPACT ANALYSIS BY STATE FOR RURAL HOSPITALS WITH FEWER THAN 100 BEDS UNDER SECTION 223 LIMITS SET AT 112 PERCENT OF MEAN COSTS

State	Number of hospitals over their limit: 1-50 beds	51-99 beds	Exempted	Basic limit (note a)	HCFA projected savings: Not considering exemptions	Considering exemptions
Alabama	4	1	0	$123.36	$ 215,152	$ 215,152
Alaska	7	1	7	214.60	227,740	183
Arizona	10	1	4	143.33	787,612	661,397
Arkansas	2	0	0	119.62	47,031	47,031
California	23	9	18	170.97	2,068,833	1,050,990
Colorado	18	2	10	123.37	518,519	196,059
Florida	3	1	1	134.92	198,632	66,651
Georgia	8	0	2	130.79	235,307	105,418
Hawaii	6	0	3	190.81	311,721	276,617
Idaho	8	3	1	141.00	251,184	241,220
Illinois	9	7	0	124.15	641,812	641,812
Indiana	2	0	0	132.01	34,969	34,969
Iowa	12	2	0	126.16	519,689	519,689
Kansas	23	4	0	122.25	651,492	651,492
Kentucky	1	0	1	124.58	14,704	0
Louisiana	11	0	4	126.12	304,674	155,046
Maine	5	2	1	133.77	204,501	183,647
Maryland	0	0	0	145.63	0	0
Massachusetts	1	0	1	152.62	114,004	0
Michigan	4	1	1	147.34	396,653	182,843
Minnesota	13	1	1	122.94	350,196	330,602
Mississippi	3	0	0	120.73	59,958	59,958
Missouri	3	4	1	125.48	329,641	174,527
Montana	15	3	9	135.85	827,724	554,275
Nebraska	8	3	2	113.12	442,457	409,357
Nevada	7	1	4	145.95	428,596	279,750
New Hampshire	1	0	0	147.98	10,613	10,613
New Jersey	0	0	0	150.20	0	0
New Mexico	2	1	2	143.20	159,076	69,139
New York	1	0	0	137.16	60,953	60,953
North Carolina	3	1	1	133.67	226,334	160,260
North Dakota	4	1	1	124.28	165,334	86,436
Ohio	1	1	0	134.60	70,413	70,413
Oklahoma	10	1	1	124.15	515,986	447,775
Oregon	9	0	4	155.04	239,224	55,602

ENCLOSURE I

State	Number of hospitals over their limit: 1-50 beds	51-99 beds	Exempted	Basic limit (note a)	HCFA projected savings: Not considering exemptions	Considering exemptions
Pennsylvania	0	1	0	$149.18	$ 22,357	$ 22,357
South Carolina	3	0	0	127.87	82,231	82,231
South Dakota	12	3	1	112.92	508,067	500,601
Tennessee	1	0	0	121.41	20,659	20,659
Texas	27	4	4	122.00	1,558,209	1,443,722
Utah	12	0	12	133.05	386,552	0
Vermont	0	1	0	134.07	49,321	49,321
Virginia	0	1	0	133.88	94,360	94,360
Washington	21	0	2	152.51	628,596	555,050
West Virginia	0	1	0	135.76	46,686	46,686
Wisconsin	6	2	0	124.14	317,654	317,654
Wyoming	6	1	7	138.89	287,733	0
Total	325	65	106		$15,633,159	$11,132,517

a/Individual hospital reimbursement limits differ from the basic limit. Because hospital cost reporting years close throughout the calendar year, HCFA adjusts the limits for each hospital to account for expected inflation differences during the differing cost reporting years. Also, the limits for a hospital are further adjusted if it has an approved teaching program.

IMPACT BY STATE OF ESTABLISHING NEW SECTION 223 LIMITS (AT 112 PERCE

FOR RURAL HOSPITALS WITH 1 TO 50 BEDS AND 51 TO 99 BE

State	1-50 beds		51-99 beds		Basic limits (note a)		GAO 1-50 beds	
	Number over limit	Ex-empted	Number over limit	Ex-empted	1-50 beds	51-99 beds	Not considering exemptions	Co sid ex ti
Alabama	3	0	3	0	$129.15	$114.49	$ 158,109	$ 1
Alaska	5	5	1	1	224.67	199.11	132,110	
Arizona	6	2	4	1	151.07	133.91	628,502	5
Arkansas	2	0	1	0	126.06	111.75	32,188	
California	23	12	15	7	179.00	158.64	1,156,649	7
Colorado	15	10	6	0	130.03	115.27	361,152	1
Florida	3	1	1	0	141.68	125.59	159,478	
Georgia	6	2	1	0	136.92	121.37	155,807	
Hawaii	5	2	0	0	199.76	178.42	264,220	2
Idaho	5	1	3	0	148.61	131.73	104,057	
Illinois	6	0	14	0	131.63	116.68	215,526	2
Indiana	1	0	3	0	138.20	122.51	22,922	
Iowa	10	0	8	0	132.08	117.08	275,329	2
Kansas	18	0	9	0	129.29	114.62	389,949	3
Kentucky	0	0	1	0	131.94	116.95	0	
Louisiana	9	4	3	0	132.04	117.04	189,564	
Maine	5	1	3	0	140.04	124.13	129,236	1
Maryland	0	0	0	0	152.47	135.13	0	
Massachusetts	1	1	1	0	160.29	142.06	88,164	
Michigan	3	0	3	2	155.81	138.10	136,611	1
Minnesota	10	1	8	0	130.19	115.40	221,592	2
Mississippi	2	0	4	0	126.80	112.40	29,704	
Missouri	2	1	8	0	131.35	116.45	153,286	
Montana	15	8	4	1	142.22	126.07	392,673	2
Nebraska	8	1	6	0	119.78	106.20	184,885	1
Nevada	6	3	2	0	152.80	135.43	284,616	1

State	1-50 beds: Number over limit	1-50 beds: Exempted	51-99 beds: Number over limit	51-99 beds: Exempted	Basic limits (note a): 1-50 beds	Basic limits (note a): 51-99 beds	GAO estimated savings: 1-50 beds: Not considering exemptions	GAO estimated savings: 1-50 beds: Considering exemptions	GAO estimated savings: 51-99 beds: Not considering exemptions	GAO estimated savings: 51-99 beds: Considering exemptions
New Hampshire	0	0	1	0	$155.40	$137.74	$ 0	$ 0	$ 3,095	$ 3,095
New Jersey	0	0	0	0	N/A	133.06	0	0	0	0
New Mexico	1	0	2	5	149.91	132.88	57,182	57,182	106,775	0
New York	1	0	3	0	144.56	128.13	29,225	29,225	103,494	103,494
North Carolina	3	1	3	0	139.93	124.04	192,852	134,257	106,304	106,304
North Dakota	3	1	3	0	130.11	115.34	124,762	48,987	101,695	101,695
Ohio	1	0	5	0	141.85	125.73	35,306	35,306	280,288	280,288
Oklahoma	7	0	1	1	130.85	116.00	396,232	396,232	152,222	0
Oregon	8	3	5	0	163.39	144.82	127,268	12,307	40,158	40,158
Pennsylvania	0	0	3	0	156.18	138.43	0	0	243,934	243,934
South Carolina	2	0	1	0	134.27	119.02	55,731	55,731	7,308	7,308
South Dakota	8	0	4	0	118.22	104.80	286,801	286,801	288,428	288,428
Tennessee	1	0	2	0	127.11	112.68	14,466	14,466	106,748	106,748
Texas	23	4	5	0	129.36	114.68	1,104,374	1,017,731	417,781	417,781
Utah	11	11	1	1	140.22	124.31	326,369	0	22,140	0
Vermont	0	0	4	2	140.80	124.80	0	0	207,072	163,554
Virginia	0	0	2	0	138.53	122.80	0	0	189,259	189,259
Washington	15	2	3	0	160.74	142.48	478,059	422,070	7,450	7,450
West Virginia	0	0	3	0	142.13	125.98	0	0	106,073	106,073
Wisconsin	3	0	9	0	131.61	116.67	69,536	69,536	559,360	559,360
Wyoming	6	6	3	1	145.41	128.88	165,647	0	131,623	4,902
Total	262	83	175	22			$9,330,139	$6,586,483	$10,121,573	$ 8,286,55

a/Individual hospital reimbursement limits differ from the basic limit. Because hospital cost reporting years close throughout the calendar year, HCFA adjusts the limits for each hospital to account for expected inflation differences during the differing cost reporting years. Also, the limits for a hospital are further adjusted if it has an approved teaching program.

ENCLOSURE III

COMPARISON OF IMPACT BY STATE OF EXISTING VERSUS REVISED

BED SIZE GROUPS (AT 112 PERCENT OF MEAN COSTS)

State	For current bed size groups		Combined total for revised bed size groups	
	Number of providers affected	Savings considering exemptions	Number of providers affected	Savings considering exemptions
Alabama	5	$ 215,152	6	$ 245,033
Alaska	8	183	6	0
Arizona	11	661,397	10	677,441
Arkansas	2	47,031	3	69,591
California	32	1,050,990	38	1,249,714
Colorado	20	196,059	21	386,539
Florida	4	66,651	4	84,235
Georgia	8	105,418	7	47,051
Hawaii	6	276,617	5	256,822
Idaho	11	241,220	8	272,659
Illinois	16	641,812	20	1,128,004
Indiana	2	34,969	4	174,379
Iowa	14	519,689	8	695,676
Kansas	27	651,492	27	787,935
Kentucky	1	0	1	66,571
Louisiana	11	155,046	12	196,330
Maine	7	183,647	8	244,939
Maryland	0	0	0	0
Massachusetts	1	0	2	92,588
Michigan	5	182,843	6	166,261
Minnesota	14	330,602	18	413,236
Mississippi	3	59,958	6	133,037
Missouri	7	174,527	10	510,519
Montana	18	554,275	19	657,384
Nebraska	11	409,357	14	614,652
Nevada	8	279,750	8	392,775
New Hamsphire	1	10,613	1	3,095
New Jersey	0	0	0	0
New Mexico	3	69,139	3	57,182
New York	1	60,953	4	132,719
North Carolina	4	160,260	6	240,561
North Dakota	5	86,436	6	150,682

ENCLOSURE III

State	For current bed size groups: Number of providers affected	For current bed size groups: Savings considering exemptions	Combined total for revised bed size groups: Number of providers affected	Combined total for revised bed size groups: Savings considering exemptions
Ohio	2	$ 70,413	6	$ 315,595
Oklahoma	11	447,775	8	396,232
Oregon	9	55,602	13	52,465
Pennsylvania	1	22,357	3	243,934
South Carolina	3	82,231	3	63,039
South Dakota	15	500,601	12	575,229
Tennessee	1	20,659	3	121,214
Texas	31	1,443,722	28	1,435,513
Utah	12	0	12	0
Vermont	1	49,321	4	163,554
Virginia	1	94,360	2	189,259
Washington	21	555,050	18	429,520
West Virginia	1	46,686	3	106,073
Wisconsin	8	317,654	12	628,896
Wyoming	7	0	9	4,902
Total	390	$11,132,517	437	$14,873,035

SCHEDULE OF SOLE COMMUNITY PROVIDER EXEMPTION

APPLICATIONS AND DECISIONS BY REGION AND STATE

	Number of applications	Number of approvals	Number of denials	Number with decision pending
Region I - Boston:				
Connecticut	3	2	1	0
Maine	4	4	0	0
Massachusetts	6	2	4	0
New Hampshire	5	5	0	0
Rhode Island	0	0	0	0
Vermont	4	4	0	0
	22	17	5	0
Region II - New York:				
New Jersey	0	0	0	0
New York	0	0	0	0
	0	0	0	0
Region III - Philadelphia:				
Delaware	0	0	0	0
Maryland	0	0	0	0
Pennsylvania	2	0	1	1
Virginia	2	2	0	0
West Virginia	1	0	0	1
	5	2	1	2
Region IV - Atlanta:				
Alabama	0	0	0	0
Florida	6	5	1	0
Georgia	3	2	1	0
Kentucky	4	1	3	0
Mississippi	0	0	0	0
North Carolina	1	1	0	0
South Carolina	1	0	1	0
Tennessee	2	1	1	0
	17	10	7	0

ENCLOSURE IV

	Number of applications	Number of approvals	Number of denials	Number with decision pending
Region V - Chicago:				
Indiana	2	0	2	0
Illinois	5	0	5	0
Michigan	8	5	3	0
Minnesota	6	3	3	0
Ohio	1	0	1	0
Wisconsin	5	0	5	0
	27	8	19	0
Region VI - Dallas:				
Arkansas	3	1	2	0
Louisiana	13	5	8	0
New Mexico	19	18	1	0
Oklahoma	19	9	10	0
Texas	8	7	1	0
	62	40	22	0
Region VII - Kansas City:				
Iowa	0	0	0	0
Kansas	6	1	5	0
Missouri	9	3	6	0
Nebraska	14	4	10	0
	29	8	21	0
Region VIII - Denver:				
Colorado	25	17	6	2
Montana	26	16	5	5
North Dakota	9	4	4	1
South Dakota	15	3	2	10
Utah	19	17	2	0
Wyoming	15	12	2	1
	109	69	21	19

ENCLOSURE IV

	Number of applications	Number of approvals	Number of denials	Number with decision pending
Region IX - San Francisco:				
Arizona	11	10	1	0
California	46	35	11	0
Hawaii	6	4	2	0
Nevada	7	6	1	0
	70	55	15	0
Region X - Seattle:				
Alaska	12	12	0	0
Idaho	2	1	1	0
Oregon	13	9	4	0
Washington	6	3	1	2
	33	25	6	2
Total	374	234	117	23